



RETIREE
RESOURCE GUIDE
2015-2016

THESE BENEFITS ARE EFFECTIVE MARCH 1, 2015 THROUGH FEBRUARY 29, 2016. If there is any variation between the information provided in this Guide, the Plan Document, or the Group Contracts, the Plan Document and Group Contracts will prevail. This guide briefly describes, in non-technical language, the benefits offered to you and your family. It is not intended to modify the group policies and/or contracts between the carriers and the county.

You may obtain a detailed description of coverage provisions including the Summary of Benefits Coverage (SBC) and the Glossary of Terms—both of which are available in English and Spanish versions— and/or Summary Plan Document (SPD) from Human Resources & Risk Management (HRRM) Employee Benefits. They are also available on the HRRM website at harriscountytexas.gov/hrrm.

All documents are available electronically and you may obtain a printed copy upon request, at no charge. Reference Page 1 for additional information about the SBC.

HUMAN RESOURCES & RISK MANAGEMENT

Employee Benefits.....(713) 274-5500
Out of Area Toll Free.....(866) 474-7475
Web: harriscountytexas.gov/hrrm, wellathctx.com

MEDICAL COVERAGE

Aetna Member Services.....(800) 279-2401
Aetna Rx—Mail Order.....(866) 612-3862
Onsite Representative.....(713) 274-5500
Resources for Living (EAP).....(866) 849-8229
Web: aetna.com & mylifevalues.com

DENTAL COVERAGE

UnitedHealthcare DHMO & PPO.....(866) 528-6072
Onsite Representative.....(713) 274-5500
Web: yourdentalplan.com/harriscounty

VISION COVERAGE

Superior Vision of Texas.....(800) 507-3800
Web: www.superiorvision.com

LONG-TERM DISABILITY PLAN

CIGNA.....(800) 362-4462
Web: cigna.com

LIFE INSURANCE

Prudential Insurance Company.....(800) 524-0542

DEFERRED COMPENSATION/457 PLANS

VALIC Retirement.....(800) 448-2542
Web: valic.com

VOYA Financial Services.....(800) 525-4225
Web: voyaretirement.voyaplans.com

Nationwide (PEBSICO).....(877) 677-3678
Web: nrsforu.com

RETIREMENT

Texas County & District Retirement System (TCDRS)..(800) 823-7782
Web: tcds.org

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IMPORTANT INFORMATION REGARDING PLAN CHANGES, RELATED DOCUMENTS, & PRIVACY

The **Summary of Benefits Coverage (SBC)**, provided separately from the Resource Guide, summarizes the key features of our medical plans including: covered benefits, cost-sharing, coverage limitations, and exceptions.

The **Glossary of Health Coverage and Medical Terms** will help you understand some of the most common language used in health insurance documents.

Both the **Summary of Benefits Coverage (SBC) for the Base & Plus Plans**, and the **Glossary of Health Coverage and Medical Terms** are available in English and Spanish versions on the Harris County website at harriscountytexas.gov/hrm, or you may obtain a printed copy upon request. To obtain a printed copy of the SBC or the Glossary of Health Coverage and Medical Terms at no charge, contact the Benefits Division at 713.274.5500 or toll free 866.474.7475 and it will be sent to you within seven days.

2015 - 2016 PLAN CHANGES

STEP THERAPY precertification is required for certain angiotensin receptor blocker (ARB drugs), angiotensin converting enzyme inhibitor (ACE inhibitors), statin (cholesterol), and diabetic prescriptions.

In compliance with the Affordable Care Act, the Maximum Out-of-Pocket for in-network services Individual/Family are now: Base Plan \$6,600/\$13,200 ; and Plus Plan \$5,600/\$11,200. The deductible, coinsurance, and medical and prescription drug copays will be applied to the maximum out-of-pocket.

Block Vision is now Superior Vision of Texas - the only that has changed is the name. Vision benefits remain the same.

POSTPONEMENT OF EXPECTED PREMIUM INCREASE

On September 23, 2014 Commissioners Court approved an increase in department funding to finance the expected increase in medical plan costs over the next plan year. Rates charged to employees and retirees who pay a portion of their coverage, as well as costs for dependent coverage, were expected to increase 3%. With the implementation of a recommended step-therapy program for certain heart, statin (cholesterol), and diabetes prescription drugs, we believe that increase could be delayed with the potential of plan cost savings from these programs. Other quality based programs such as pharmacy advisor, migraine management and Heart Care for Life were implemented as well.

Harris County's medical plan will continue to implement any necessary benefit and administrative changes as required by the Affordable Care Act (ACA) and to conform to healthcare industry standards.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN REQUEST ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR "NOTICE OF PRIVACY PRACTICES"

This Notice is for participants and beneficiaries in the Plan. As a participant or beneficiary of the Plan, you are entitled to receive this Notice of the Plan's privacy procedures with respect to your health information that the Plan creates or receives (your "Protected Health Information" or "PHI"). Our "Notice of Privacy Practices" was updated to comply with new changes to the Health Information Portability and Accountability Act ("HIPAA") effective as of March 26, 2013.

This Notice is intended to inform you about how we will use or disclose your PHI, your privacy rights with respect to PHI, our duties with respect to your PHI, your right to file a complaint with us or with the Secretary of the United States Health and Human Services ("HHS"), and how to contact our office for further information about our privacy practices. This Notice and the most updated "Notice of Privacy Practices" will be posted at harriscountytexas.gov/hrm or you may request a copy by calling 713.274.5500.



ANNUAL ENROLLMENT FACTS FOR MEDICAL, DENTAL & VISION

Annual enrollment for the 2015/2016 plan year will be conducted from December 1 through December 31, 2014. Changes become effective March 1, 2015. You should carefully consider the insurance plans available to you and your dependents. **Retirees cannot add dependents at annual enrollment. See Qualified Status Change information on bottom right of this page.**

We are committed to providing you with a comprehensive benefits program. Our program allows you to customize your benefits package to best suit your needs and the needs of your family. Annual enrollment is your opportunity to make allowable changes to your benefits. This Resource Guide is designed to help you through the enrollment process.

Medical and dental plans each offer two options. Reference pages 18-20 and 23-25 for plan details. Everyone in your family must choose the same plan.

IF YOU ARE NOT MAKING ANY CHANGES - DO NOT RETURN YOUR FORM.

Are you a retired Public Safety Officer?

If so, you can have your insurance premiums deducted from your TCDRS pension check on a pre-tax basis.

Tired of receiving a bill each month, writing a check and mailing your insurance premium to the County?

Don't risk losing your coverage due to a late payment when you can enroll in direct debit today and your premiums will always be paid on time.

Choices made during open enrollment will remain in place until the following enrollment period.

Retirees who do not return their completed annual enrollment paperwork indicating desired changes will be defaulted to their benefit selections chosen for the 2014-2015 plan year.

QUALIFIED STATUS CHANGE

Retirees may experience life changes during the calendar year, and a change form is required to drop or add dependents.

Qualified Status Changes include:

- ◆ Birth of your child
- ◆ Adoption or placement of a foster child
- ◆ Marriage, divorce, or death
- ◆ Dependent loses other health insurance coverage
- ◆ Significant change in the financial terms of health benefits provided through dependent's employer or another carrier
- ◆ Loss of eligibility for Medicare or Medicaid
- ◆ Loss of State Children's Health Insurance Program (SCHIP)

Requests to add dependents must be made within the same calendar year in which the qualified status change occurred. You will be responsible for absorbing the entire cost for your existing and newly added dependents.

FAILURE TO DROP DEPENDENTS when required under this health plan may be considered **INSURANCE FRAUD** and may result in a referral to the District Attorney's office for investigation. Further, any retiree committing insurance fraud will be liable to reimburse the County for claims activity.

NOTE: Retirees may drop dependents at any time.

ELIGIBILITY & CHOOSING THE RIGHT PLAN



Submitting required documentation is key to adding dependents to your coverage.

Spouse: A filed copy of a Formal Marriage License or Certificate of Informal Marriage.

Children: A birth certificate listing the employee as the parent. A certificate of birth facts may be submitted up to age of five; however, a birth certificate is required for age five and up. Coverage is available up to age 26.

Legal Custody or Guardianship: Court documents, signed by a judge, granting permanent legal custody or permanent legal guardianship to retiree. Coverage is available up to age 18.

Stepchildren: A birth certificate or other court document listing the retiree's spouse as parent of the child, and the marriage license of the retiree and parent of the child. Coverage is available up to age 26.

Grandchildren:

- ⇒ Certification of Financial Dependency form (obtain from department Benefit Coordinator),
- ⇒ Birth certificate of the grandchild, and
- ⇒ Birth certificate of the grandchild's mother or father.
- ⇒ Coverage is available up to age 26.
- ⇒ The grandchild must be related to the retiree by birth or adoption and cannot be your spouse's grandchild.

NOTE: *Grandchild must be claimed as a dependent on the retiree's Federal Tax return every year to remain on the plan. A Grandchild Audit occurs in June of each year.*

Adopted Children: Certified copy of court order or paperwork placing child in your home.

Foster Children: Foster care placement agreement between the retiree and the Texas Department of Family & Protective Services or its subcontractor.

CHOOSING THE BEST PLAN FOR YOU AND YOUR DEPENDENTS

should be based on several things such as your personal medical condition and usage of services, financial situation, and your level of comfort with coinsurance vs. copayments.

Copayments do not apply to the annual deductible. The following definitions may assist you in the decision-making process.

Copayment: the predetermined dollar amount you will pay for a service (examples: physician office visits, walk-in clinics, urgent care, emergency room, physical therapy, counseling).

Coinsurance: percentage employee is responsible for paying up to a specific dollar amount per calendar year. Covered services are paid from 50%-100% depending on the plan selected, service rendered, and place of service.

Deductible: initial out-of-pocket costs that must be paid before the plan begins to pay benefits (Base Plan In-Network \$500 and Plus Plan In-Network \$0).

The **Base** plan has set copayments for some in-network services, but requires coinsurance for ambulance, durable medical equipment, hearing aids, complex imaging, home health care, hospice, inpatient hospitalization, outpatient surgery, physician hospital services, private-duty nursing, and skilled nursing facility. The **Base** plan also has a \$500 per individual in-network deductible with an individual maximum out-of-pocket limit of \$6,600 per calendar year. The deductible and coinsurance only apply where services are not indicated as set copayments.

The **Plus** plan has set copayments for most in-network services; however, this plan has a higher monthly premium contribution. The individual maximum out-of-pocket limit is \$5,600 per calendar year.

Your Aetna Choice POS II Plans do not require you to select a network primary care physician (PCP), although selecting a PCP is encouraged. These plans also allow you to self-refer to a specialist. Your choice of provider dictates the amount you will pay in copayments, coinsurance and/or deductibles.

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME) IS A COVERED BENEFIT

BASED ON THE FOLLOWING CONDITIONS:

No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- ◆ made to withstand prolonged use;
- ◆ made for and mainly used in the treatment of a disease or injury;
- ◆ suited for use in the home;
- ◆ not normally of use to a person who does not have a disease or injury;
- ◆ not for exercise or training.

The accessories needed to operate your **Durable Medical Equipment (DME)** are covered under your DME benefit at 90% after deductible for Base Plan members and at 100% for Plus Plan members when using in-network providers.

A COMPREHENSIVE LIST OF PARTICIPATING PROVIDERS is available at aetna.com.

Contracted providers may have more than one office and it is possible that one or more offices are not considered “in-network.” To avoid additional cost, please make sure that the provider you are seeing is “in-network” at the location of your visit.

If a provider orders a test or procedure for you, be sure to ask if it is experimental or investigational.



Some procedures must be pre-certified!



OUT-OF-NETWORK COVERAGE

Harris County has limits on authorized costs associated with Out-of-Network facilities/providers. In an effort to maximize the highest level of benefit coverage, advise your participating physician to refer you only to in-network facilities and providers with Aetna. This will result in savings for both you and the county.

To help curb excessive out-of-network facility/provider costs, the county has established a Limited Out-of-Network reimbursement that limits the Plan’s exposure to unreasonable costs for non-emergency services and procedures. If you use an out-of-network facility or provider, you will be responsible for paying the difference between the covered amount and the amount the facility charges. Non-covered expenses will not apply to your out-of-pocket maximum.

It is YOUR responsibility to make sure your physician, facility, or hospital is in-network or you will pay out-of-network costs. You can help keep costs down by using in-network providers. For information on participating providers, go to www.aetna.com and select “Find a Doctor, Pharmacy or Facility.”

NOTE THE FOLLOWING:

- ◆ There are no out-of-network benefits for health care services provided by **North Cypress Medical Center**. The only exceptions are for true emergency care provided in the emergency department and emergency in-patient admissions.
- ◆ If you are currently on dialysis, coverage is provided in-network **ONLY** and must be precertified. Providers should call 866-503-0857.

In need of LAB SERVICES?

You **must** obtain your lab services through an Aetna approved lab such as **Quest Diagnostics**. If you fail to do so, the services will be paid as an out-of-network benefit subject to deductibles and coinsurance.



Your Health and
Wellness Resource

all is well at Harris County

Begin your journey to better health and wellness! Harris County Employee Wellness provides both onsite and web-based services that will help you improve your overall health!

GET ACTIVE

Participate in community events, onsite exercise classes, Live Healthy Harris County challenges, and the HC Employee 5K. Take advantage of gym membership discounts with the YMCA and GlobalFit.

STAY WELL

Enroll in programs such as Naturally Slim that can help you stay well and better manage your condition.

KNOW YOUR RISK


Take your online health assessment to learn your overall risk, or visit the Wellness Clinic at 1310 Prairie Street to have a routine mammography and/or your annual physical.

BE INFORMED

Take a hands-on cooking class to learn a new, healthy recipe or watch a wellness class online! Get one-on-one health coaching services with the RD on the Go program.

CELEBRATE SUCCESS

Harris County has been recognized annually for its efforts in improving employee wellness. Share your own health accomplishments to help inspire and motivate others!



Find out more about all programs
and services offered by Harris
County Employee Wellness!

Visit wellathctx.com

Questions?

Call: 713.274.5500

Email: wellness@bmd.hctx.net

Social Media: [!\[\]\(1f56542a42e2413e44a2b2023033aa2e_img.jpg\) /wellhctx](https://www.facebook.com/wellhctx)

FITNESS DISCOUNTS

Aetna FitnessSM Discount Program

Get preferred rates at your choice of over 10,000 gyms in the GlobalFit network.

You also get:

- ⇒ **FREE** guest pass at most gyms
- ⇒ **Flexible** membership options
- ⇒ **Easy** billing through your bank account or credit card

Save on home exercise equipment

Build your home gym with discounts on elliptical trainers and treadmills. Also available are resistance bands, mats, yoga accessories, and more.

Choose from GlobalFit's national network of gyms. To find a participating gym in your area, visit globalfit.com/fitness.

You can view details about any gym, including rates and amenities, and register for membership online or by calling GlobalFit toll free at 800.298.7800. A GlobalFit representative can answer your questions, send you a free guest pass, and help you join the gym of your choice.

Examples of some of the gyms in the metro Houston area include 24-Hour Fitness, Jazzercise, Curves, Anytime Fitness and many other independent local gyms.

YMCA Corporate Membership Discount



Join the YMCA for a discounted rate!

Harris County is now a Corporate Member of the YMCA of Greater Houston, which entitles you to some **GREAT BENEFITS** at any YMCA in Greater Houston!

Benefits of Corporate Membership

- Your joining fee will be waived! That's a savings of up to \$100!
- Pay nothing when you join! Your first month will be free, up to 30 days!
- Membership rates can be based on household income for those who qualify.
- City-wide membership so you can access the YMCA close to work as well as close to home!

PLUS, 10% off all programs! From Personal Training to Massage Therapy to Sports Leagues, Summer Camp, and Swim Lessons, you'll get an additional 10% off the Corporate City-wide Facility Member Program Rate as a Citywide Corporate Member.

Visit wellathctx.com and select "Get Active" for more information on free services!



Aetna Health ConnectionsSM Condition Management Programs

This program is designed to help you or your eligible family member(s) learn more about your conditions and work closely with your doctor to improve your health and quality of life. Educational information is provided, and for high-risk members, access to a registered nurse "Health Coach" is offered. To learn more about Disease Management programs, login to aetna.com, select "Health Programs," then "Disease Management Program." No computer...no problem! Just call 866.269.4500 to get started in disease management.

If you receive a call or letter from Aetna, please return their call or contact them as requested.

ALL INFORMATION IS CONFIDENTIAL WITH AETNA AND IS NOT SHARED WITH HARRIS COUNTY.

Aetna Compassionate CareSM

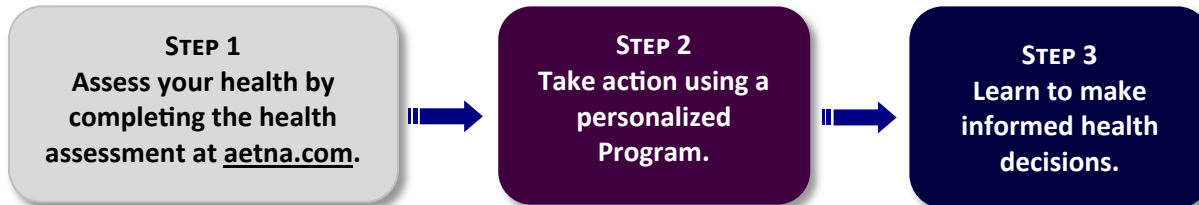
This is a comprehensive program to provide expanded benefits, nurse support, and information to retirees and their families who are facing end-of-life and palliative care issues. Case management and bereavement services are covered up to twelve (12) months.

Palliative care aims to relieve physical symptoms of disease and provides emotional and spiritual support to patients and family members. Respite care provides short-term services to seriously ill individuals and relieves primary care givers of some of the burden.

For more information visit:

aetnacompassionatecareprogram.com

Simple Steps To A Healthier Life[®] Program



When you feel good, it's easier to enjoy the people and things you love most. Simple Steps To A Healthier Life is an interactive online health and wellness program that can help you improve or maintain your health in ways that fit your lifestyle.

You start by taking an online Health Assessment that will help identify some of your health needs. Questions focus on health habits and all answers are kept secure and confidential. You'll get free online wellness coaching programs through HealthMedia[®] and learn strategies to fit healthy living into your busy life, at your own pace.

Online programs to help YOU reach YOUR goals

Manage your weight: Reach your goal weight, and boost how active you are with Balance [™] .	Sleep better: Beat sleepless nights with strategies from Overcoming [™] Insomnia.
Deal with stress: Find out where your tension comes from, and get proven strategies to stay calm under pressure with Relax [™] .	Quit Smoking: Get a quit plan that uses your strengths to help you get past old roadblocks with Breathe [™] .
Eat healthier: Get counseling one-on-one to learn better eating habits for life with Nourish [™] .	Be happier: Whether you have the blues or it's something more serious, you can get confidential help that gets results with Overcoming [™] Depression.

WHAT IS CASE MANAGEMENT AND DO I REALLY NEED IT?

SOMETIMES A PHONE CALL MAKES ALL THE DIFFERENCE IN THE WORLD and personalized help makes it easier for you to be healthy and well. That's why your Aetna program offers phone support from a caring registered nurse. Help is available when you need that support the most or when you just need a little advice.

For special situations, we know the health care system can be complicated. Just think of all the times you spoke with someone knowledgeable in health care issues, and how it put your mind at ease. Times when you are:

- ⇒ Planning for or coming home from a hospital stay
- ⇒ Managing a medical condition, like asthma or diabetes
- ⇒ Coordinating complex medical treatment among different doctors, hospitals, labs and other health care providers



The results are an improved relationship with your entire health care team

QUIT TOBACCO WITH THE AETNA HEALTHY LIFESTYLE COACHING PROGRAM

Break the habit of using tobacco for good! The Healthy Lifestyle Coaching Tobacco Free program is at no cost to you or your covered members. The program includes:

- Telephonic coaching sessions with an experienced wellness coach
- Access to online peer support available 24/7 (monitored by a wellness coach)
- Educational materials
- Extra support to address personal concerns, like maintaining your weight and managing stress
- Up to **TWO, 90-day prescriptions** for smoking cessation medication
- **Extra Rewards:** Free 8-week supply of nicotine replacement therapy is yours for completing 3 sessions with a coach. Or you may choose a \$25 Corporate Rewards gift card instead. At your 6-month coaching session, you will automatically earn a \$25 gift card.



Get started today! Call **866.213.0153** or log in to aetna.com and complete your health assessment.



YOUR CONVERSATION IS PRIVATE

- ◆ It's in your best interest to talk openly with your program nurse.
- ◆ Rest assured that everything you discuss is confidential.
- ◆ Aetna never shares your information with anyone, including your employer.
- ◆ So be sure to answer the phone when Aetna calls.
- ◆ It's a phone call that can make a big difference.



Diabetes
America

Are You Diabetic? If so, it's important for you to have the best possible care and monitoring available to control your condition.

NO OFFICE VISIT
COPAYS

DiabetesAmerica is your "one-stop-shop" for diabetes care.

It provides comprehensive diabetes care, management, and education services at a single location with no office visit copay.

DiabetesAmerica services include:

- Physician care
- Certified diabetes education
- Certified diabetes nutritional counseling
- Exercise and lifestyle counseling and support
- Case management and monitoring
- Telephonic support/website access
- Eye, foot, and cardiovascular screenings
- Onsite labs
- Annual retinal exam
- Free glucose monitor

For locations, information, and appointments, call **866.693.4223** or visit diabetesamerica.com.

Beginning RightSM Maternity Program—Do it for yourself and your baby!

Every mother expects to have a healthy baby. It doesn't matter if you've been through this before—every pregnancy is different. Enrolling in the Beginning RightSM maternity program provided by Aetna ensures you will have access to vital prenatal and postnatal information! This benefit is available for you and your covered dependents. Use it throughout the pregnancy and after your baby is born.

Learn what's best for a healthy pregnancy:

- Receive materials on prenatal care, labor and delivery, newborn care, and more.
- Get information for Dad or partner.
- To help prevent/decrease the risk of your baby's stay in a Neo-natal Intensive Care Unit (NICU), take the pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy and/or your baby's health. Also, you'll receive a small gift if you take the survey by your 16th week of pregnancy.

Get special attention when you need it most! If you have issues or risk factors that need special attention, Aetna nurses will provide you personal case management and find ways to lower your risks.

If you or a covered member of your family is pregnant, contact Aetna to pre-certify the pregnancy at 1-800-CRADLE-1 (1-800-272-3531).



BREASTFEEDING SUPPLIES & LACTATION SUPPORT

To receive a complimentary breast pump, you must obtain a prescription from your OB/Gyn and present it to a participating Durable Medical Equipment (DME) provider. For a list of providers, go to [aetna.com](https://www.aetna.com).

The plan will pay for one electric breast pump in a 36-month period within 60 days of birth, 1 manual pump in a 36-month period within 12 months of birth, and one (1) set of breast pump supplies on alternate years from receipt of the pump.

Lactation Support and Counseling:

Six visits per year to a qualified lactation consultant for either individual or group classes. Any additional visits (7+) will be covered according to the plan's provisions.

aetnaSM What is Aexcel[®]?

Aexcel is a designation for specialists in Aetna's performance network that have met certain standards for clinical performance and efficiency. These standards include managing Aetna patient volume, adhering to clinical guidelines, external recognition, and board certification information specific to the physician's Aexcel specialty, and demonstrating overall effectiveness in the delivery of care. Aexcel specialists are available in the following categories of care:

Cardiology	Obstetrics/Gynecology
Cardiothoracic Surgery	Orthopedic Surgery
Gastroenterology	Otolaryngology (ENT)
Neurology	Plastic Surgery
Neurosurgery	Urology
General Surgery	Vascular Surgery

For example, if you obtain specialty services from a Cardiologist or Neurologist, etc., or any other Aexcel specialty, you will have a **\$40 copay on the Base Plan and a \$30 copay on the Plus Plan**. However, if you seek specialty services through an Aexcel specialty category such as cardiology and do not see an Aexcel designated cardiologist, **your copay on the Base Plan is \$50 and on the Plus Plan is \$40**.

Since Aexcel only applies to twelve specialties, if you are enrolled in the BASE PLAN and you see a specialist who is not in one of the twelve categories, you will pay the lower specialist office visit copay of \$40 (Base). In the PLUS PLAN, only the providers in the twelve specialties that are Aexcel designated are subject to the lower copay of \$30.



Using Aexcel-designated providers will save you \$10 per visit on copays. To find an Aexcel specialist, login to [aetna.com](https://www.aetna.com) and select "Find a doctor, pharmacy or facility." Aexcel specialists are indicated with a blue star.

Informed Health® Line

gives you easy access to credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year, on demand from your touch-tone phone. If you prefer to view health information online, simply login to aetna.com, select “Health Programs,” then click on the link for the *Healthwise® Knowledgebase*.

24-Hour Nurse Line	Speak with a registered nurse who has experience in a variety of health topics at any time of the day.*
Audio Health Library	Phone in and choose from thousands of common health topics. Easily transfer to the Nurse Line for questions.
Healthwise® Knowledgebase	Search for detailed information about health conditions, medical tests and procedures, medications, and treatment options.

**Informed Health Line Nurses cannot diagnose, prescribe, or give any medical advice. Contact your physician with any questions or concerns regarding your health care needs.*

**To reach the 24-Hour Nurse Line or Audio Health Library
call 800.556.1555.**



To access, login to aetna.com and begin learning everything you ever wanted to know about health and medical conditions.

Aetna IntelliHealth® is an exclusive resource that can be accessed online to find up-to-date health information and resources including:

- Information on diseases & conditions
- Articles on lifestyle improvement
- Gender and age-specific health issues
- Medication information
- Health assessments
- Quizzes
- Medical dictionary
- Health calculators (BMI, etc.)
- Current health research news
- “How-to” slide shows
- Emailed health updates

Professional Care Management Aetna Resources for LivingSM

Do you have an adult loved one who might need a little more care? Now you can get expert help.

Professional Care Management: A valuable benefit to have at no cost.

Professional Care Management costs can range from \$85-\$200 an hour and are often not covered by insurance or Medicare.

We can help put your mind at ease

Each year, you can get up to six hours of free guidance from highly-trained Professional Care Managers (PCMs) to help a care recipient you are responsible for. Here’s what the PCM can do for you:

Home Assessment. After a visit with you and your loved one, the PCM will give you a written plan tailored for your loved one’s present and future needs. This will cover:

- Physical and mental condition
- Housing and support needs
- Support systems (friends, neighbors, emergency services, and more)
- Legal, financial, and insurance needs

Your care plan will include steps you can take to make things better. It’ll also give you resources to help along the way.

Facility Review. The PCM will tour selected care facilities to give you an idea of the level of quality you can expect from them.

Hospital visits and aftercare assessments. The PCM will visit your loved ones while still in the hospital to perform a needs assessment. Often the PCM will also look into the home or facility where your loved one will be going for aftercare.

Ongoing care coordination. To support your loved one’s needs, the PCM can make appointments, call for medical services, pay bills, set up community services, and more.

Easy to get started

One confidential call is all it takes to get started. A specialist will work with you to schedule an appointment with a PCM that’s convenient for you and your family members.

**Call 866.849.8229 or
visit mylifevalues.com (username & password: EAP4HCTX)**



Aetna Resources For LivingSM

Confidential assistance is available 24 hours a day, 7 days a week when using Aetna **Resources For Living** (formerly Employee Assistance Plan, a.k.a. EAP).

This is a service provided as part of your benefits to you or any member of your household at no additional cost. You can turn to **Resources for Living (EAP)** for help with anything that interferes with your job or personal life such as:

Stress management	Family or parenting issues
Substance abuse/misuse	Work/life balance
Burnout	Marital/relationship problems
Child and elder care	Anxiety
Depression	Anger management
Legal concerns	Financial issues
Coping with change	Self-esteem

We understand that some days it can be tough to manage the competing priorities in our lives and keep them running smoothly. Sometimes life can become work and work can become your life. Either way, there is help for you balance the two. Maybe you just need someone to talk to about a recent transition or conflict at work, or maybe you're looking for some guidance with your personal relationships.



Benefits of Resources For Living:

- ⇒ 8 FREE face-to-face counseling sessions *per issue*, per year
- ⇒ Free initial legal consultation and discounts on continuing legal consultation services
- ⇒ Free initial financial consultation
- ⇒ Online discounts and access to a full range of web-based tools and resources
- ⇒ Most importantly, all information is confidential between Aetna Resources for Living and you!

WHAT ARE YOU WAITING FOR?

Visit mylifevalues.com
and enter
Username: EAP4HCTX
Password: EAP4HCTX

or call 866.849.8229

**ASSISTANCE IS JUST A PHONE CALL
OR CLICK AWAY FOR
FREE SERVICES!**

Most people think of an EAP as a place to call when they have a crisis or an urgent need for emotional or mental health support. **Resources For Living** removes the stigma that often comes with the term EAP and continues to provide that same level of support while adding assistance with all of the following:

- ⇒ Work/life balance
- ⇒ Improved lifestyle
- ⇒ Better physical and mental health
- ⇒ Total well-being

Make HistorySM - Personal Health Record

You can make history by putting the Aetna® Personal Health Record to work for you. This secure, private, online resource makes it easy for you to view, access, and manage your health information—and share it with your doctors.

- Keep your health information in one place—it's always available for you to access in an emergency.
- Share your history with your doctor by printing your record and taking it to your next visit!
- **Maintain or even improve your health.** Based on your health profile provided by insurance claims and information you enter yourself, the Personal Health Record generates personalized health-related alerts and reminders that can help you address your health needs in a timely manner.
- With your user name and password, you control who sees your information. You may add information to the record at any time.
- It's easy to get started! Just create a user name and password on the secure Aetna Navigator member website at aetna.com.



aetnaSM WE HAVE AN “APP” FOR THAT!

The Aetna Mobile app is available for Android™ smartphones, iPhone®, iPod touch®, iPad™, and BlackBerry® Curve™ models. The Aetna application or “app” enhances the capabilities of Aetna Mobile Web by leveraging key Android smartphone functions. Similar to the Aetna app for iPhone and Blackberry users, the Aetna apps are free and allow members to:

- ☑ Search for a doctor or facility based on their current location and get turn-by-turn directions with the built-in Global Positioning System (GPS)
- ☑ View their Aetna ID card information
- ☑ Check the status of recent claims
- ☑ Access their Personal Health Record to view items like “Alerts & Reminders, Emergency Information, Medications and Tests & Procedures” while on the go
- ☑ Get a drug cost estimate before a prescription is filled
- ☑ View their coverage and benefits

To download the app...

- ⇒ Android™ users go to the Marketplace and search for “Aetna” to download the app.
- ⇒ iPhone®, iPod touch®, and iPad™ users can simply tap the App Store logo, then type “Aetna Mobile” in the search box.
- ⇒ BlackBerry® Curve™ users go the BlackBerry App World™ storefront and download the Aetna mobile app.



RECOMMENDED PREVENTIVE HEALTH/SCREENING/VACCINE

Hepatitis B (HepB)	3-4 doses—1 dose at birth; 1 dose 1-2 months later; 1 dose at 4 months of age; and 1 dose between 16-18 months
Hepatitis A (HepA)	2 doses—1 dose between 12 and 23 months of age and 1 dose at least 6 months later
Rotavirus	2-3 doses—1 dose each at 2, 4, and 6 months of age
Diphtheria-Tetanus-Pertussis (DTaP)	5 doses—1 dose each at 2, 4, and 6 months of age; 1 dose between 15 and 18 months of age; and 1 dose between 4 and 6 years of age
Inactivated Polio (IPV)	4 doses—1 dose each at 2 and 4 months of age; 1 dose between 6 and 18 months of age; and 1 dose between 4 and 6 years of age
H. Influenza Type B (Hib) (may be combined with DTaP) & Pneumococcal Conjugate (PCV)	4 doses—1 dose each at 2, 4, and 6 months of age; and 1 dose between 12 and 15 months of age
Measles-Mumps-Rubella (MMR) & Chicken Pox (Varicella)	2 doses—1 dose between 12 and 15 months of age; and 1 dose between 4 and 6 years of age
Influenza	Every flu season—beginning at 6 months of age
Meningococcal	1 dose between 11 and 12 years of age
Tetanus-Diphtheria-Pertussis (Tdap)	1 dose between 11 and 12 if the childhood DTP/DTaP series is complete and has not received Td booster
Human Papillomavirus (HPV)	3 doses (females) between 11 and 12 years; second dose 2 months later, third dose 6 months after 1st dose
Blood Pressure	Every 2 years—18 years of age and older
Body Mass Index (BMI)	Periodically—18 years of age and older

Cholesterol	Government guidelines state that healthy adults who are age 20 years or older should have a cholesterol test done once every 5 years.
Glucose (diabetes blood sugar test)	Beginning at age 45, then every 3 years unless you have other risk factors; then testing should occur every year
Mammogram	Every 1-2 years—women 40 years of age and older
Cervical Cancer	Every 1-2 years—Beginning at 21 years of age or earlier if sexually active; if 30 years of age and older, either a Pap Smear every 2-3 years after 3 consecutive normal results or HPV DNA test plus a Pap smear every 3 years if results of both tests are negative. Women 70 years of age and older may stop screening.
Chlamydia	Routinely—women 24 years of age and younger if sexually active
Osteoporosis (Bone Density Test)	Routinely—women 65 years of age and older
Prostate Cancer	Between 50-75 years of age—yearly screening with high-sensitivity fecal occult blood testing, or sigmoidoscopy every 5 years with high-sensitivity fecal occult blood testing every 3 years
Colonoscopy	Men and women beginning at age 50, once every 10 years
Depression/Alcohol Misuse/ Tobacco Use	Routinely—18 years of age and older
Tetanus-Diphtheria-Pertussis (Td/Tdap)	1 dose Td booster every 10 years
Pneumococcal	1 dose—65 years of age and older
Zoster (shingles)	1 dose—60 years of age and older

NOTE: Preventive health, screening and vaccines are a covered benefit on our plans based on frequency and age-specific guidelines indicated.

URGENT CARE CENTERS & WALK-IN CLINICS in the Greater Houston Area

Don't use an Emergency Room when a visit to a physician's office, walk-in clinic, or urgent care center is adequate! Use the lowest level of care appropriate for your immediate need.



\$20-\$25 for Walk-In Clinic

Some of the facilities listed on the following pages are considered "walk-in clinics" and they are marked with an asterisk (*) and shaded gray. These clinics generally offer similar services to urgent care centers and are staffed by nurse practitioners. Your copay at the walk-in clinics is only \$25 on the Base Plan and \$20 on the Plus Plan.

\$50 for Urgent Care

Urgent care facilities generally result in shorter wait times, lower expenses, and less out-of-pocket cost for our retirees since the copayment is \$50 per visit versus the hospital emergency room copayment of \$300.

Urgent care facilities fill a critical need for patients when they are seeking immediate care that is not life-threatening and their general practitioner is unavailable. If a patient feels like their situation is life-threatening, then they should seek help in the appropriate setting or call 9-1-1. Retirees should continue to coordinate their care with the advice of their primary care physicians.

Advantages: Lower copayment & shorter wait time!

This summary is intended for reference purposes only, and medical conditions vary by individual. Always use your best judgment when seeking treatment for you and your family.

\$300 for EMERGENCY CARE

PURPOSE: Necessary life-threatening treatment that could place a patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part.



DISADVANTAGES:

- ⇒ Higher copayment of \$300 per visit
- ⇒ Higher cost to the health plan
- ⇒ Extended wait time depending on severity of the issue

WHAT ARE STANDALONE ERs?

Many standalone emergency care centers are located near shopping centers for easy consumer accessibility and convenience; however, **they charge double or triple the amount of a physician's office or urgent care center and are NOT designed to treat life-threatening illness.**

Your copayment will be \$300 and you may have to pay additional fees for transport and admission to a hospital. We urge our retirees and their dependents to be responsible, educated health care consumers when determining the appropriate treatment facility.

HOSPITAL ADMISSION & EMERGENCY ROOM INFORMATION

If a member is admitted to an out-of-network hospital through the emergency room, clinicians from Aetna's Utilization Management area will confirm the admission was clinically necessary. If it is determined the admission is not a true emergency, it will be covered at the out-of-network benefit level. This means you will have to pay a larger portion of the bill at the out-of-network hospital.

Occasionally members brought to the emergency room are not always admitted, but placed under observation. Coverage for observation in a hospital emergency room is limited to 24 hours. At such time, the member must either be admitted or discharged, but cannot remain in holding in the emergency room or the balance may be billed by the provider.

URGENT CARE CENTERS & WALK-IN CLINICS in the Greater Houston Area

North (Montgomery County)			Conroe, The Woodlands, Spring Montgomery, Porter, & Kingwood		
MinuteClinic* (CVS)	25110 Grogans Mill Rd., Spring	(866) 389-2727			
Nextcare Urgent Care	15320 Hwy 105 W #120, Montgomery	(936) 582-5660			
Nextcare Urgent Care	1331 Northpark Dr., Kingwood	(281) 359-5330			
Oaks Urgent Care	25410 IH 45 North, Spring	(281) 363-5600			
RediClinic* (H-E-B)	130 Sawdust Road, Spring 10777 Kuykendahl Road, Spring	(281) 419-3162 (281) 907-4104			
Take Care* (Walgreens)	24917 FM 1314 Road, Porter 8000 Research Forest, The Woodlands	(866) 825-3227			
Texas Family Medical & Minor Emergency Center	1331 Northpark Drive, Kingwood	(281) 359-5330			
Urgent Care for Kids	1640 Lake Woodlands, The Woodlands	(281) 367-0010			
E/NE (Liberty County)					
Quality Care Plus	2718A North Main Street, Liberty	(936) 336-3616			
North/NW/NE (Harris County)			Cypress, Humble, Kingwood, Spring, Houston, Huffman, & Tomball		
Champions Urgent Care	4950 FM 1960 West, Suite A6	(281) 444-1711			
Concentra Health Services, Inc.	401 Greens Road, Houston 6360 W Sam Houston Pkwy N, Suite 200 8799 N Loop East, Suite 110	(281) 873-0111 (713) 280-0400 (713) 674-1114			
Convenient Urgent Care	411 W Parker Road, Houston	(713) 691-3300			
Doctors Express Urgent Care	10850 Louetta Rd #1500, Houston	(281) 320-2338			
CyFair Urgent Care	9110 Barker Cypress Rd., Cypress	(281) 517-9900			
Excel Urgent Care	25801 U.S. Hwy. 290, Cypress	(281) 304-1100			

North/NW/NE (Harris County)			Cypress, Humble, Kingwood, Spring, Houston, Huffman, & Tomball		
Kingwood Urgent Care & Special Clinic	2601 W Lake Houston Pkwy, Kingwood	(281) 360-7502			
Medsprings Urgent Care	1450 Kingwood Drive, Kingwood	(832) 548-4420			
Minute Clinic* (CVS)	8000 N Sam Houston Pkwy E, Humble 24802 Aldine Westfield, Spring 8754 Spring Cypress Rd, Spring 26265 NW Frwy, Cypress 12550 Louetta Road, Cypress	(866) 389-2727 (866) 389-2727 (866) 389-2727 (866) 389-2727 (866) 389-2727			
Next Level Urgent Care	15882 Champion Forest Drive, Spring 8100 Hwy 6 N, Suite E, Houston	(281) 809-6615 (832) 304-2314			
Nextcare Urgent Care	10906 FM 1960 Road West	(281) 477-7490			
Only Choice Urgent Care	11515 FM 1960 #C, Huffman	(281) 324-1550			
Night Light Pediatric Urgent Care	19708 NW Frwy #500, Houston	(713) 957-2020			
RediClinic* (H-E-B)	28520 Tomball Pkwy., Tomball 4303 Kingwood Drive, Houston 10919 Louetta, Houston 24224 Northwest Frwy, Cypress 7405 FM 1960 East, Humble	(281) 255-3085 (866) 607-7334 (281) 758-2282 (866) 607-7334 (866) 607-7334			
Take Care* (Walgreens)	1215 W 43rd St, Houston 7440 FM 1960 Road East, Humble 19710 Holzwarth Road, Spring 16211 Spring Cypress Rd, Cypress	(866) 825-3227 (866) 825-3227 (866) 825-3227 (866) 825-3227			
Westfield Urgent Care	2010 FM 1960 East, Houston	(281) 821-8200			

IMPORTANT INFORMATION...

Walk-in clinics are marked with an asterisk (*) and shaded gray. Your copay at the walk-in clinics is only \$25 on the Base Plan and \$20 on the Plus Plan.

URGENT CARE CENTERS & WALK-IN CLINICS in the Greater Houston Area

East (Jefferson County) Beaumont, Nederland, & Port Arthur		
Doctors Express of the Beaumont Area, P.A.	3195 Dowlen Rd #105, Beaumont	(409) 860-1888
Mid County Urgent Care	4700 Hwy 365 #J, Port Arthur	(409) 729-1900
MinuteClinic* (CVS)	2712 Hwy 365, Nederland	(866) 389-2727
East/Southeast/South (Harris County) E. Houston, Baytown, Pasadena, Deer Park, Clear Lake Area, & Central Houston		
Baytown Urgent Care Limited	2800 Garth Road, Baytown	(281) 425-3835
Beamer Urgent Care	10851 Scarsdale Blvd #130, Houston	(281) 481-9595
Concentra Health Services, Inc.	10909 I-10 East Frwy, Houston 8505 Gulf Frwy, Suite F, Houston 125 East 8th Street, Deer Park	(713) 973-7943 (713) 944-4442 (281) 930-8555
East Houston Urgent Care	11410 I-10 East #168, Houston	(713) 453-9800
Immediate Medical Care	1202 Nasa Parkway, Nassau Bay 525 Blossom St, Webster 6825 Spencer Hwy, Pasadena	(281) 335-0606 (281) 724-1885 (281) 741-0070
MinuteClinic* (CVS)	2469 Bay Area Blvd, Houston 3505 Center St, Deer Park 9828 Blackhawk Blvd, Houston	(866) 389-2727 (866) 389-2727 (866) 389-2727
Normandy Urgent Care	779 Normandy St. #114, Houston	(713) 453-8900
Primary Urgent Care	2802 Garth Rd #111, Baytown	(281) 838-8575
RediClinic* (H-E-B)	6210 Fairmont Pkwy, Pasadena	(832) 775-0165
Take Care* (Walgreens)	16185 Space Center Blvd, Houston 3300 Center Street, Deer Park	(866) 825-3227 (866) 825-3227

Southeast/South (Galveston County) Friendswood, League City, & Galveston		
Calder Urgent Care	1100 Gulf Frwy #230, League City	(281) 557-4404
Immediate Medical Care	3354 FM 528, Friendswood 2640 E League City Pkwy #114, League City	(832) 569-5739 (281) 538-8000
RediClinic* (H-E-B)	701 W Parkwood Drive, Friendswood 2955 South Gulf Frwy., League City	(281) 947-0018 (281) 337-7351
West Isle Urgent Care	2027 61st Street, Suite B, Galveston	(409) 744-9800
South/Southwest (Brazoria County) Angleton, Lake Jackson, & Pearland		
Immediate Medical Care	2705 Broad St, Pearland	(281) 412-0508
Minute Clinic* (CVS)	2900 E Broadway St, Pearland 9522 Broadway St, Pearland	(866) 389-2727 (866) 389-2727
Options Urgent Care & Wellness Center	208 Oak Dr #502, Lake Jackson	(979) 285-2273
Pearland Healthcare Center	1801 Country Place Pkwy #109, Pearland	(713) 436-4333
Prime Urgent Care	2510 Smith Ranch Rd #102, Pearland	(713) 340-3111
RediClinic* (H-E-B)	2805 Business Ctr. Dr., Pearland	(713) 436-5208
Take Care* (Walgreens)	8430 Broadway St., Pearland	(866) 825-3227

IMPORTANT INFORMATION...

Walk-in clinics are marked with an asterisk (*) and shaded gray. Your copay at the walk-in clinics is only \$25 on the Base Plan and \$20 on the Plus Plan.

URGENT CARE CENTERS & WALK-IN CLINICS in the Greater Houston Area

Central /Southwest (Harris County)			Houston		
Concentra Health Services, Inc.	9321 Kirby, Houston 6545 Southwest Frwy, Houston 2004 Leeland, Houston	(713) 797-0991 (713) 995-6998 (713) 223-0838			
Doctors Express of the Beaumont Area, P.A.	5568 Wesleyan St, Houston	(713) 666-7050			
Doctors Express Urgent Care	107 Yale St #200, Houston	(713) 861-6060			
Houston Medical Care	5568 Wesleyan Street	(713) 666-7050			
Medsprings Urgent Care	1917 W Gray St, Houston	(832) 260-0650			
Memorial Urgent Care	14629 Memorial Drive, Houston	(281) 589-8500			
Minute Clinic* (CVS)	5402 Westheimer Rd #K, Houston 3939 Bellaire Blvd, Houston 1003 Richmond Ave, Houston	(866) 389-2727 (866) 389-2727 (866) 389-2727			
RediClinic* (H-E-B)	2660 Fountainview	(713) 343-2699			
Take Care* (Walgreens)	1919 W Gray Street, Houston 5200 Westheimer Road, Houston 2808 N Gessner Road, Houston	(713) 526-3621 (713) 623-0643 (713) 460-0535			
West/Southwest (Fort Bend County)			Katy, Missouri City, Stafford, & Sugar Land		
Excel Urgent Care	6840 Hwy 6, Missouri City	(281) 403-3660			
Medsprings Urgent Care	1403 Hwy 6, Suite 100, Sugar Land 6501 S Fry Road, Katy	(832) 260-0640 (832) 260-0670			
Next Level Urgent Care	16902 SW Frwy #108, Sugar Land 8720 Hwy 6 S #400, Missouri City	(832) 342-9205 (832) 342-9204			
Night Light After Hours Pediatrics	15551 Southwest Frwy., Sugar Land	(281) 325-1010			

West/Southwest (Fort Bend County)			Katy, Missouri City, Stafford, & Sugar Land		
RediClinic* (H-E-B)	6711 South Fry Road, Katy 8900 Highway 6, Missouri City 19900 Hwy. 59, Sugar Land 23675 Nelson Way, Katy	(281) 395-5080 (281) 778-0622 (281) 341-8330 (281) 347-7700			
Southwest Urgent Care	19875 Southwest Frwy., Ste 100 Sugar Land	(281) 545-2323			
Take Care* (Walgreens)	6768 Hwy. 6 South	(281) 530-9768			
Texas Children's Urgent Care	9727 Spring Green Blvd #900, Katy	(281) 789-6300			
Urgent Care for Kids	23730 Westheimer Pkwy #N, Katy	(281) 392-3033			
West (Harris County)			Katy & West Houston		
Concentra Health Services, Inc.	1000 N Post Oak Rd #G-100, Houston 12345 Katy Freeway, Houston	(713) 686-4868 (281) 679-5600			
Entrust Immediate Care	9778 Katy Frwy #100, Houston	(713) 468-7845			
Excel Urgent Care	19450 Katy Frwy, Houston	(281) 829-9900			
Family Plus Urgent Care	15881 FM 529, Suite A, Houston	(832) 427-1871			
Katy Urgent Care Partners	21700 Kingsland Blvd., Ste. 104, Katy	(281) 829-6570			
Medsprings Urgent Care	14045 Memorial Drive, Houston	(832) 548-4410			
Minute Clinic* (CVS)	3103 N. Fry Road, Katy 5603 FM 1960 W, Houston	(866) 389-2727 (866) 389-2727			
RediClinic* (H-E-B)	9710 Katy Frwy, Houston	(713) 932-8800			
Take Care* (Walgreens)	411 South Mason Rd., Katy	(281) 579-0910			
Texas Children's Urgent Care	12850 Memorial Dr #210, Houston	(832) 827-4000			
West Oaks Urgent Care	2150 South Hwy. 6, Suite 100	(281) 496-4948			

The urgent care centers and walk-in clinics listed are current providers and may be subject to change. It is your responsibility to check the provider's status and hours of operation when you seek services.

MEDICAL BENEFITS COMPARISON—BASE PLAN VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Plan Deductible per Individual /Family (Per Calendar Year)	\$500 Individual \$1,500 Family	\$1,000 Individual \$3,000 Family	None	\$1,000 Individual \$3,000 Family
Maximum Out-of-Pocket—including deductible, coinsurance, medical and Rx copays (Per Individual/Family Per Calendar Year)	\$6,600 Individual \$13,200 Family	\$9,000 Individual \$27,000 Family	\$5,600 Individual \$11,200 Family	\$9,000 Individual \$27,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	\$1,000,000	Unlimited except where otherwise indicated	\$1,000,000
Acupuncture	Up to \$500 per calendar year (no deductible or coinsurance applies)	Up to \$500 per calendar year (no deductible or coinsurance applies)	Up to \$500 per calendar year (no deductible or coinsurance applies)	Up to \$500 per calendar year (no deductible or coinsurance applies)
Alcohol & Drug Abuse Services—Inpatient	80% after deductible	50% after deductible	\$500 per confinement copay	60% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after \$40 copay	50% after deductible	100% after \$40 copay	60% after deductible
Allergy Testing—including serum, injections, and injectable drugs (Allergy Specialist only)	100% after \$40 office visit copay (waived for injection if no office visit charge)	50% after deductible	100% after \$40 office visit copay (waived for injection if no office visit charge)	60% after deductible
Ambulance	90% after deductible	90% after deductible	100% coverage	100% coverage
Basic Infertility Services—Diagnosis & Treatment	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded
Chiropractic	\$40 copay, up to \$600 per calendar year (no deductible or coinsurance applies)	50% after deductible; up to \$600 per calendar year	\$30 copay, up to \$600 per calendar year (no deductible or coinsurance applies)	60% after deductible; up to \$600 per calendar year
Complex Imaging—MRI, PET, CT scan, etc. (pre-certification required)	90% after deductible	50% after deductible	\$100 copay	60% after deductible
Diagnostic X-ray and Laboratory	100% coverage	50% after deductible	100% coverage	60% after deductible
Durable Medical Equipment	90% after deductible	50% after deductible	100% coverage	60% after deductible

NOTE: Limits for the Base and Base Plus Plans are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations, and exclusions.

MEDICAL BENEFITS COMPARISON—BASE PLAN VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Emergency Room	\$300 copay, waived if admitted	\$300 copay, waived if admitted	\$300 copay, waived if admitted	\$300 copay, waived if admitted
Hearing Aids—one pair every 36 months with a maximum benefit of \$1,500	80% coverage, no deductible	80% after deductible	80% coverage, no deductible	80% after deductible
Home Health Care (100 visits per calendar year)	90% after deductible	50% after deductible	100% coverage	60% after deductible
Hospice Care—Inpatient & Outpatient	90% after deductible	50% after deductible	90% after \$250 deductible	60% after deductible
Hospital Services—Inpatient	80% after deductible	50% after deductible	\$500 per confinement copay*	60% after deductible
Hospital Services—Outpatient	80% after deductible	50% after deductible	100% after \$300 copay for surgical procedures, 100% coverage for non-surgical	60% after deductible
Maternity (coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense	Payable as any other covered expense	Payable as any other covered expense
Mental Health—Inpatient coverage	80% after deductible	50% after deductible	100% after \$500 per confinement copay	60% after deductible
Mental Health—Outpatient coverage	100% after \$30 copay	50% after deductible	100% after \$30 copay	60% after deductible
Outpatient surgery (facility) (Except in physician's office when office visit copay applies)	80% after deductible	50% after deductible	100% after \$300 copay	60% after deductible
Physician Hospital Services	80% after deductible	50% after deductible	100% coverage	60% after deductible
Preventive Care** (Routine physicals, immunizations, and tests)	100% coverage	50% after deductible	100% coverage	60% after deductible

*For inpatient maternity, copayment applies to mother and each child delivered.

**PREVENTIVE CARE—In accordance with the Affordable Care Act (ACA), preventive care services include age appropriate or risk status screenings, standard immunizations recommended by the American Committee on Immunization Practices, and all United States Preventive Services Task Force A and B recommendations. Examples of these services include well-child immunizations and exams, well-man and woman exams, and screenings as adopted by HHS guidelines.

NOTE: Limits for the Base and Base Plus Plans are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations, and exclusions.

MEDICAL BENEFITS COMPARISON—BASE PLAN VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Primary Care Physician Visits (excludes Mental Health/Alcohol/Drug)	100% after \$25 copay	50% after deductible	100% after \$20 copay	60% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	100% after \$40 copay 100% after \$50 copay	50% after deductible	100% after \$30 copay 100% after \$40 copay	60% after deductible
Private Duty Nursing—Outpatient (70 shifts per calendar year— requires precertification)*	90% after deductible	50% after deductible	100% coverage	50% after deductible
Residential Treatment Facility	80% after deductible	50% after deductible	\$500 copay	60% after deductible
Routine Gynecological Care Exam Coverage is limited to one routine OB/Gyn exam per calendar year including charges for one pap smear and related fees.	100% coverage	50% after deductible	100% coverage	60% after deductible
Routine Mammography—Ages 35-40 one baseline; age 40+, one every calendar year	100% coverage	50% after deductible	100% coverage	60% after deductible
Short-Term Rehabilitation—physical, speech, & occupational therapy (60 visits per calendar year)	100% after \$25 copay	50% after deductible	100% after \$20 copay	60% after deductible
Skilled Nursing Facility (up to 100 days per calendar year and requires precertification)*	90% after deductible	50% after deductible	100% coverage	60% after deductible
Urgent Care Provider	100% after \$50 copay	50% after deductible	100% after \$50 copay	60% after deductible
Walk-in Clinics	100% after \$25 copay	50% after deductible	100% after \$20 copay	60% after deductible
Women’s Health—includes well woman exam, screening, testing , contraceptives, breast feeding supplies/support*	100% coverage	50% after deductible	100% coverage	60% after deductible

*Reference the Summary Plan Document available at www.harriscountytexas.gov/hrrm for details regarding coverage.

HARRIS COUNTY PRESCRIPTION DRUG BENEFITS

	Percentage You Pay	Minimum Copay	Maximum Copay
RETAIL			
Generic	25%	\$5	\$35
Brand	30%	\$25	\$100
Specialty	30%	\$50	\$200
MAIL ORDER			
Generic	25%	\$10	\$70
Brand	30%	\$50	\$200



Price-A-Drug

BEFORE YOU GO TO THE PHARMACY OR MAIL YOUR PRESCRIPTION TO AETNA RX HOME DELIVERY, CHECK PRICE-A-DRUG AT aetna.com. Price-A-Drug provides cost information for prescriptions at both retail and mail order so you can determine the least expensive method prior to having the prescription filled.

You can also use this online feature to obtain information about less expensive bioequivalent or therapeutic alternatives, or contact Aetna Member Services at 713.274.5500 or toll free 800.279.2401.

THIS IS A MANDATORY GENERIC PLAN

Prescriptions written for a brand medication will be dispensed as a generic, if available (or becomes available while the Rx is active). If a brand medication is necessary, the doctor must write/sign DAW (dispense as written) or brand necessary on the prescription. If this is not on the script and a generic is available, the member will receive the generic medication.

If the member or physician requests brand name when a generic is available, the member pays the brand copay plus the difference between the generic price and the brand price.

Aetna Rx Step Program

Precertification is required for angiotensin receptor blocker (ARB drugs), angiotensin converting enzyme inhibitor (ACE inhibitors), statin (cholesterol), and diabetic prescriptions.

With step-therapy, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first, or unless the prescriber obtains a medical exception.

The plan will not cover certain step-therapy drugs if your prescriber does not prescribe a prerequisite drug first or fails to obtain a medical exception unless the corresponding prerequisite therapy drug(s) are used first.

Prerequisite therapies and any medical exception prescriptions will be subject to dose and quantity recommendations outlined by the manufacturer.

SPECIALTY MEDICATIONS AND/OR SELF INJECTIBLE DRUGS

are available only for a 30-day supply through the Aetna Specialty Pharmacy OR an Aetna designated and approved provider after the third fill at a retail pharmacy.

MAINTENANCE PRESCRIPTIONS

If you recently filled a maintenance prescription, and your physician changed/increased your dosage, or if you are just reordering the maintenance medication and you are sending in a new prescription, you must have used 2/3 of your prescription prior to mailing in your new prescription.

The County's prescription drug benefit excludes bulk chemicals.

- ♦ All compound drugs made with bulk chemicals included on Aetna's Bulk Chemical Exclusion List as amended and administered for Harris County will be excluded from coverage.
- ♦ Covered compound drugs will require a brand level member copay responsibility.

IMPORTANT PRESCRIPTION DRUG INFORMATION

Would you like to save money on your prescriptions?

The **Save-A-Copay Program** is a consumer-focused, VOLUNTARY program that offers retirees and/or their dependents a prescription drug copayment savings opportunity. If you are currently utilizing one of the following brand name drugs and are willing to switch to a lower cost preferred generic drug, you will have no copayments for six months! If you qualify for this program, Aetna will send a letter to you encouraging your participation.

The below list of Drug Class and Targeted Drugs is subject to change without notice.

Drug class	Targeted drugs
Antidepressants (SSRIs)	Paxil CR, Lexapro, Cymbalta
Migraine	Imitrex, Maxalt, Maxalt MLT, Alsuma Injection, Amerge, Axert, Frova, Migranal, Relpax, Sumavel, Treximet, Zomig,, Zomig ZMT, Cambia powder
Proton Pump Inhibitors (PPIs)	Aciphex, Protonix
Seizure Disorder (Anti-epileptics)	Topamax, Lamictal XR, Oxtellar XR
Attention Deficit Disorders (Stimulants)	Concerta, Focalin XR, Quillivant SUS XR, Adderall XR
Sleep Disorders (Hypnotics)	Ambien, Lunesta, Rozerem, Sonata, Edluar, Zolpimist Spray, Intermezzo sub
Nasal Steroids	Beconase AQ, Rhinocort, Flonase, Nasacort AQ
Non Sedation Antihistamines (NSAs)	Clarinet/D, Xyzal
Benign Prostatic Hypertrophy (BPH)	Flomax
Overactive Bladder (OAB)	Detrol, Detrol LA, Ditropan XL, Sanctura, Sanctura XR, Toviaz
Acne	Retin-A, Minocin, Dynacin, Duac, Doryx, Benzefoam, Benzaclin

This program is available for prescriptions filled at participating retail and mail order pharmacies. When using mail order, you will not pay any copayments on two 90-day fills.

Each person's treatment is unique. Talk to your doctor first to find out if a preferred generic drug may be right for you.

Filing paper claims for your prescriptions? Talk to your pharmacist about calling Aetna Pharmacy Management for assistance in submitting your claim electronically, especially if you have two insurance carriers.

Multiple Prescriptions: If you submit new prescriptions all on one script, and not all are available at one time, the order could be delayed by 24-48 hours. If the remaining prescription(s) are not available within the 7-10 day processing period, the order will then be split into 2 separate orders in an effort to avoid further delay.

Faxing prescriptions: Physicians can fax prescriptions for mail order processing. The prescription must be submitted on the physician's office letterhead and must include the member's name and Aetna identification number. Prior to processing faxed prescription(s), the member must have completed and submitted an ARxHD registration form. Members cannot fax prescriptions for

TAKING A TRIP? If you know you will run out of your prescription medication, and it is too soon to refill prior to your departure, call Aetna Pharmacy Management (APM) for a "Vacation Override" at 800.238.6279. You will need to provide your departure date and return date to the representative. Medication can be picked up as early as 3 days prior to your vacation departure date. In most instances you will receive a maximum three-month supply of medication.



UNITED HEALTHCARE DENTAL PLANS - DHMO & PPO PLAN OPTIONS

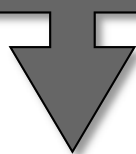
OPTIONS: Harris County offers your dental benefits through UnitedHealthcare Specialty Benefits and continues to provide two dental options:

- ⇒ A Dental Health Maintenance Organization (DHMO) and a Dental Preferred Provider Organization (PPO) plan.
- ⇒ Either plan is available to retirees and included in the cost (if applicable) of the medical plan.
- ⇒ If you choose to enroll your dependents, you will be responsible for their portion of the monthly premium.

QUESTIONS? UNITEDHEALTHCARE CUSTOMER SERVICE STAFF ARE AVAILABLE Monday-Friday, 7 a.m.-10 p.m. CST at 866.528.6072. Select "0" to speak to a representative.

You can check eligibility, claims, determine out-of-pocket costs using the Treatment Cost Calculator, and print or request your plan information...either online or through advanced telephone technology.

Call 866.528.6072



Register for online access at:

yourdentalplan.com/harriscounty (registration and login button located at the bottom center of the home page) or call the toll-free number on your member ID card and follow the prompts for IVR (Interactive Voice Recognition) assistance.

UnitedHealthcare Dental HMO*	UnitedHealthcare Dental PPO**
No calendar year maximums; no yearly deductibles	\$1,750 calendar year maximum; \$50 yearly individual deductible (\$150 for family)
Basic care provided by network general dentists selected at enrollment. Members may change their designated dentist by contacting UnitedHealthcare Dental customer service by the 20 th of the month. Requested changes will be effective the first of the following month.	You may receive care from any licensed dentist; network dentists have agreed to accept negotiated fees as payment in full with no "balance billing."
Each family member may select a different UnitedHealthcare Dental network general dentist (remember to include the Practice ID number when enrolling).	Non-network dentists could "balance bill," which may result in higher out-of-pocket costs. For more information, see the Benefit Summary or determine out-of-pocket costs by using the online Treatment Cost Calculator.
Covered procedures and copayments are listed on the Schedule of Benefits and may be found at: yourdentalplan.com/harriscounty	All claims are paid based on the percentages of the Maximum Allowable Charge.
When specialty care is required, your selected general dentist and UnitedHealthcare Dental Customer Service Representative will assist in managing your referral.	If you require specialty care, you may see any specialty care dentist you choose. When you receive care from a network dentist, you may save on your cost of care.
No waiting periods.	New enrollees: 6-month waiting period on endodontic procedures and all major services (newly-added dependents of current retirees).
Adult & child orthodontics is included in the DHMO plan.	Orthodontia is <u>not</u> a covered benefit in the PPO plan.
No claim forms are required.	Claim forms may be required when a non-network dentist is used.

*Benefits for the UnitedHealthcare Dental DHMO plans are provided by the following: UnitedHealth Group Company, National Pacific Dental, Inc.

**Benefits for the UnitedHealthcare Dental PPO plans are provided by UnitedHealthcare Insurance Company, located in Hartford, Connecticut.

COMPARE THE DHMO AND PPO DENTAL PLANS TO MAKE THE RIGHT DECISION FOR YOU AND YOUR FAMILY

WHICH PLAN IS BEST FOR ME?

The DHMO plan provides comprehensive dental care with defined copayments for each covered procedure. You select a participating DHMO dentist from a network of providers and follow the plan rules/guidelines for services provided.

The PPO plan offers members a choice of dentists in-network, and the option to go out-of-network for services at a higher cost share. The plan includes an annual deductible and a calendar year maximum. With this plan, you pay a higher percentage of costs for services.

Choose the plan that best suits your needs for the upcoming benefit year.

UnitedHealthcare DHMO Plan

Remember to select a dentist from the *United Healthcare* Dental Directory or Dentist Locator on yourdentalplan.com/harriscounty for yourself and each of your enrolled dependents. Indicate the Practice ID Number in the space on your enrollment form for each person enrolled.

You can obtain a complete Schedule of Benefits with covered procedures and copayments along with Exclusions & Limitations, available online at harriscountytexas.gov/hrrm or yourdentalplan.com/harriscounty. You may also request a copy by calling customer service at the number located on your member ID card.

An Evidence of Coverage document may also be requested or viewed online and provides additional information about how to get the most from your *UnitedHealthcare* Dental HMO plan. Please take time to review this information before making dental benefit decisions.

DHMO members: Check out the dental health and wellness link at yourdentalplan.com/harriscounty.

UnitedHealthcare PPO Plan

There is no need to pre-select a dentist - you can receive treatment from any dentist, network or non-network. If you decide to use a network dentist, you can log on to yourdentalplan.com/harriscounty to browse the Dental Directory or Dentist Locator to help you find a dentist. When choosing a dentist, if you choose to receive care from a *UnitedHealthcare Dental* network dentist, you could save on your out-of-pocket costs. Network dentists have agreed to negotiated fees as payment in full with no balance billing.

Your PPO Costs

Payment of claims is based on a Maximum Allowable Charge (MAC). The Maximum Allowable Charge is set by *UnitedHealthcare Dental* and uses negotiated rates with network dentists. This MAC is the most that *United Healthcare Dental* pays for a plan's covered dental procedure.

A Summary of Benefits includes the information about percentage of coverage by procedure category along with Exclusions & Limitations. After reviewing the plan documents, if you have any questions, a customer service representative will be happy to help you. Or, you may download a copy of the Certificate of Coverage at harriscountytexas.gov/hrrm.

Included with your PPO Dental Plan:

Prenatal Dental Care Program: Women in their second and third trimesters are eligible for this program. When visiting your dentist, you need to supply the name and contact number of your OB/GYN. You will then receive additional cleanings or periodontal maintenance, at little or no cost, if the need is determined by your dentist.

Oral Cancer Screening: Individuals who are determined at-risk by their dentist and are 30 years of age or older may be eligible for this once-yearly, light-contrast screening.

DENTAL WELLNESS AND ESTIMATING THE COST OF TREATMENT

WELLNESS SCREENING Included with your Dental HMO and PPO:

- The UnitedHealthcare Dental Wellness plan, through its eight (8) Centers of Excellence, created a program that makes wellness a priority by performing a variety of unique services. By simply visiting the dentist, individuals might find that they may save more than their teeth and gums. It may just lead to early diagnosis, referral for, and treatment of a variety of diseases.
- The Centers of Excellence offer free, possibly life-saving, wellness screening services. Members set an appointment and complete a questionnaire. The dentist makes an assessment and provides appropriate screening(s) for any or all of four conditions.
- Screenings may help determine if a member is “at-risk” for oral cancer, diabetes, or cardiovascular disease, and may lead to a referral for these conditions.
- As part of the wellness visit, attending dentists provide counseling and materials about the impact of tobacco use, obesity, and oral piercings, as well as information about oral disease and other medical conditions.
- Contact the UnitedHealthcare Dental Onsite Representative at 713.274.5500 to locate a Center of Excellence near you!

What is the difference between Routine Cleaning and Deep Cleaning?

“Routine Cleaning” (prophylaxis) is the removal of normal tartar build-up and polishing teeth to remove stains. If you see your dentist regularly and have your teeth cleaned twice a year, a routine cleaning will likely be your dentist’s prescription.

“Deep Cleaning” is a term used to describe scaling and root planing, a procedure that removes plaque and tartar build-up on teeth below the gums. Usually, when you need a deep cleaning, it is a sign that your oral health has changed, typically due to gingival (gum) inflammation. There could be several reasons for the change...periodontal disease, stress, pregnancy, tobacco use, or a change of medication – even a simple change in brushing or flossing habits.

How much your dental treatments will cost

UnitedHealthcare Dental is committed to helping make the most of your dental plan benefits, by getting actual prices for treatments based on your individual plan, comparing the rates charged by different providers, and seeing your out-of-pocket cost so you can plan ahead. We have created an easy-to-use tool: the Treatment Cost Calculator.

With the Treatment Cost Calculator, you can always make an informed choice about your dental treatments. It's easy to use and available to members 24 hours a day at myuhcdental.com.

HERE'S HOW IT WORKS:

1. To get started, visit myuhcdental.com and select Plan Info > Treatment Cost Calculator.
2. At the next screen, log in with your username and password. If you haven't previously registered at myuhcdental.com, you can register now.
3. At the next screen, you'll enter information about the practitioner performing the procedure.
You'll need the following information:
 - ◆ The approximate date of the procedure
 - ◆ The Practitioner ID. To find the ID of a network practitioner, click the link to search for dentists who perform the procedure.
4. At the next screen, you'll enter information about your procedure. Select the procedure from the list of common treatments shown. You can also enter the procedure code, if you know it, or display a list of procedure codes.
5. Your treatment cost results will be displayed, including the cost of the service based on your specific plan; the amount you're responsible for (coinsurance); any limitations or waiting periods in your plan; and your annual deductible, which is the amount you must pay each year before your plan starts paying benefits.
6. From the treatment cost results page, you can display your dental benefits summary, which lists your plan features, including in and out-of-network coverage rates, your annual deductible, and your annual maximum.

IMPORTANT DENTAL INFORMATION

It's been said that people typically visit their dentist more often than they visit other doctors. It's important to know that as health care becomes more integrated and dentists increasingly focus on more than just teeth, they are becoming indispensable members of the larger health care team.

The bacteria that inhabit the mouth, causing tooth decay and gum disease, may be found elsewhere in the body. Though there may be no pain or noticeable symptoms, this bacteria can lead to far more serious conditions. We are continuing to learn that gum disease may heighten the risk for heart disease, diabetes, pregnancy complications, and other conditions.

UnitedHealthcare Dental DHMO Specialty Care Referrals and Emergency Dental Services Instructions:

Customer Service: 866.528.6072, Hours: 7 a.m. - 10 p.m. CST

Specialty Care Referrals - Certain dental procedures may require the expertise of a specialist and require a specialty care referral. Your assigned primary care dentist is responsible for completing the specialty referral form. With your form in hand, contact Customer Care for an authorization number and a specialist authorized to provide your care.

Emergency Dental Services - If you are within seventy-five (75) miles of your Selected General Dentist, simply contact your selected dentist who will make reasonable arrangements for such emergency dental care. If you are more than seventy-five (75) miles from your Selected General Dentist, or you cannot reach your Selected General Dentist or Customer Service, you may obtain Emergency Dental Services from any licensed dentist. Potential examples of emergency are excessive bleeding, severe pain, or acute infection. Reference the Dental Plan Documents for specifics at harriscountytexas.gov/hrrm.

In a non-emergency situation, you will receive an explanation of benefits via the mail that will list the specialist contact information and your authorization number. **For emergency situations**, you will receive a call back from your approved participating specialist.

FILLING OPTIONS TO CONSIDER

"Fillings" - Amalgam is the silver filling that dentists have been using for many years to fill cavities; resin-based composite fillings are white (tooth colored). You may have heard about the safety concern of using amalgams because mercury is part of the filling material; however, the American Dental Association, the National Institutes of Health, and the U.S. Public Health Service, among others, have stated that, when combined with other metals, as it is in amalgam, it is an acceptable standard of treatment.

Because some dentists have a concern about using amalgam material, they choose to provide only composite fillings for their patients. We suggest you discuss with your dentist his or her practice policies.

"Crowns" - A crown is a metal cap that covers and strengthens a tooth. Crowns are generally necessary along with a root canal or when a standard filling is not enough support for the tooth structure. Crowns are made of different materials - metal only or a porcelain ("tooth-colored"). A crown is not just the cap that sits over the tooth...there can be other procedures and materials required, such as a gold post, a core build up, or a pin. Each one adds to the total cost.

Crown costs vary depending on the materials used and your dentist can provide an itemized treatment plan. For the DHMO plan, each covered crown is listed on your Schedule of Benefits. Check the copayment and any additional fees that are indicated [i.e. porcelain on back teeth and additional lab fees for noble (low gold) and high noble (high gold) metals].

Other procedures may be required during your treatment, such as a root canal - this adds to the cost of restoration. Under the PPO plan your benefit allowance is 50%, whether your dentist is in or out-of-network. The out-of-network dentist may balance bill for services above the maximum allowable charge fee schedule. You have greater savings when you choose a network dentist.



The Harris County Vision Care Program is offered through Superior Vision.

Vision coverage is provided automatically for you and each dependent you enroll in the medical plan.

With the vision plan, when you use participating providers you will pay lower out-of-pocket expenses and receive a higher level of benefits. You may also use out-of-network benefits; however, your benefit level is reduced - you will pay for the services and you must file a claim with Superior Vision for reimbursement.

HOW THE VISION CARE PROGRAM WORKS

Each time you need vision care, you may seek care through the Superior Vision of Texas benefit plan. Select a Superior Vision participating provider by calling customer service at 866.265.0517, or visit superiorvision.com. When you make your appointment, identify yourself as a Harris County Superior Vision Vision Plan member. A vision examination is provided by a network optometrist or ophthalmologist once every twelve months.

At an in-network provider, members will receive a \$130 retail allowance towards the cost of the frame. The Superior Vision benefit plan provides \$130 toward your contact lens evaluation and fitting fee as well and the cost of contact lenses. A \$300 Lasik benefits reimbursement is also available either in or out-of-network in lieu of other benefits.

COVERED SERVICES

Highlights of your vision care benefits are shown in the chart. Copayments are not applicable when utilizing out-of-network providers.

For the complete schedule of benefits, reference the Vision Plan Benefit Certificate of Coverage at harriscountytexas.gov/hrmm.

Vision Benefit Coverage - Available In or Out-of-Network

All benefits are available once every 12 months from last date of service.

Service/Product	In-Network	Out-of-Network
Complete Visual Exam	\$10 copay	Up to \$35
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <div style="width: 20px; height: 10px; background-color: blue; margin: 0 auto;"></div> <div style="width: 20px; height: 10px; background-color: blue; margin: 0 auto;"></div> </div> <div>CHOOSE GLASSES OR CONTACTS</div> <div style="text-align: center;"> <div style="width: 20px; height: 10px; background-color: blue; margin: 0 auto;"></div> <div style="width: 20px; height: 10px; background-color: blue; margin: 0 auto;"></div> </div> </div>		
Materials (when purchasing eyeglasses, lenses, frames, OR contacts in lieu of eyeglasses)	\$25 copay	—
Frames	\$130 retail allowance after \$25 materials copay	Up to \$70
Single Vision* Lined Bifocal* Lined Trifocal* Lenticular Lenses*	Standard basic lens covered at 100% after \$25 Materials copay	Up to \$25 Up to \$40 Up to \$45 Up to \$80
Contact Lenses—Elective	\$130 retail allowance after \$25 Materials copay	Up to \$80
Contact Lenses—Necessary**	100% after \$25 Materials copay	Up to \$150
Lasik Vision Correction***	\$300 benefit	\$300 retail benefit

* Standard basic lens coverage included in your \$25 copay for glasses lenses or frames and lenses. Lens cost that exceeds the basic coverage is the member's responsibility. Members may receive a discount of up to 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage.

** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Superior Vision concerning the reimbursement that Superior Vision will make before you purchase such contacts.

***Lasik Vision Correction: Superior Vision provides each member a \$300 allowance available both in and out-of-network. Superior Vision has partnered with the LCA. In-network providers may offer additional savings and financing. Call 877.557.7609 for assistance in coordinating your care.

IMPORTANT INFORMATION ABOUT MEDICARE DIRECT

Enjoy effortless claim filing for your Medicare Part B supplemental expenses! How can you simplify filing your supplemental claims? If you are currently enrolled in Medicare Part B and Aetna is your secondary carrier, the answer is Medicare Direct! Medicare Direct is an electronic service that eliminates your need to file claims for supplemental benefits! Medicare pays its share of the expenses, and then automatically forwards any remaining expenses directly to Aetna. All you have to do is wait for your supplemental reimbursement from Aetna — no more time-consuming paperwork to fill out.

Medicare Direct offers the following advantages for you and your eligible dependents (if also covered under Medicare Part B):

An end to paperwork - Once you are enrolled in Medicare Direct, you won't have to send forms or Explanation of Medicare Benefits (EOMB) statements to Aetna in order to get your supplemental benefit (as long as you've filed a Medicare Part B claim within the last year.)

Quicker turnaround - The Medicare Part B carrier sends your claims straight to Aetna with no time wasting middle steps and **no postage** - Medicare Direct connects Medicare and Aetna electronically, eliminating postage.

HERE'S HOW MEDICARE DIRECT WORKS FOR YOU

- **Visit your provider**
- **Provider submits the claim to Medicare**
- **Medicare pays its portion of the claim and sends it directly to Aetna for processing**
- **Aetna pays covered expenses and notifies you**

Once your provider files a claim for your Medicare Part B expenses with your Medicare Part B carrier, Medicare Direct takes care of the rest. It does just what the name suggests. After Medicare has paid its share of the expenses, Medicare forwards your remaining expenses **directly** to Aetna. There's no waiting for EOMB statements. There are no claim forms to fill out — no EOMB forms to copy — no postage costs. And there's no cost to you!

How will I know if my claim has been forwarded to Aetna?

Check each Explanation of Medicare Benefits (EOMB) statement to be sure it includes a remark similar to "unpaid charges have been forwarded to your complementary insurer." Your complementary insurer is Aetna. If the remark is not there, you will need to file the claim yourself, as you do today.

Does my doctor need to know?

YES. You should tell your doctor you are enrolled in Medicare Direct. With Medicare Direct, it's important that your doctor not submit claims to Aetna for supplemental benefits. Medicare will file claims automatically to Aetna if your doctor accepts Medicare assignment. If s/he has opted out of Medicare, you must file your claim with Medicare and then Aetna will pay secondary as an out-of-network claim. For more information reference page 29 of this Guide.

Getting started is easy. As the retiree, you have been automatically enrolled in Medicare Direct if your Medicare Number is your Social Security number, followed by the letter "A". If your Medicare Number is not your Social Security number followed by the letter "A", you are not enrolled in Medicare Direct. We are unable to automatically enroll your spouse/eligible dependent. To do so, contact Aetna directly at 800.279.2401. Please do not mail claim forms, as it will delay the processing of your claim. If you have a claim that needs to be filed before your enrollment in Medicare Direct, you will need to send it to the address on your medical ID card. There is no charge to you for this service. So, be sure to register as soon as you are eligible. **That's all there is to it!**



LIFE INSURANCE & MEDICARE REVIEW

Basic Life Insurance for Retirees provided by



Prudential

Harris County provides life insurance protection for your family in the event of your death.

Annual rate of basic earnings at retirement

Benefit

\$20,000 or more	\$12,500
\$15,000 but less than \$20,000	\$10,000
\$10,000 but less than \$15,000	\$7,500
Less than \$10,000	\$ 5,000*

*Some retirees may have less than \$5,000 coverage depending on their salary upon retirement.

MEDICARE PARTS A & B

Medicare becomes the primary insurer when a retiree, or a dependent of a retiree, turns 65 or becomes eligible due to disability. Harris County medical benefits then become secondary to Medicare.

The Harris County Medical Plan coordinates its benefits with Medicare Parts A & B. Since Medicare is the primary insurance, it must pay benefits first before the Harris County Medical Plan will pay benefits. The Harris County Medical Plan will pay benefits as if Medicare Part B paid first even if you are not enrolled in Medicare Part B. This will cause a gap in your coverage if you do not enroll in Medicare Part B as a retiree.

You should contact the Social Security Administration at 800.772.1213 if you have any questions concerning coordination of benefits between the Harris County Medical Plan and Medicare.



A WORD ABOUT PROVIDERS ACCEPTING MEDICARE...

If your physician accepts Medicare assignment s/he will bill Medicare for you. If your physician does not accept Medicare assignment and/or has opted out of Medicare, you may be responsible for filing your claim with Medicare yourself. Effective 3/1/2013, Aetna will not pay primary for retirees who are eligible for Medicare if your provider has opted out of Medicare. You should ensure that all of your medical providers participate in Medicare and are in Aetna's network to receive the highest level of benefits. Failure to do so will result in higher out-of-pocket costs for you.

MEDICARE PART D

Harris County Medicare eligible retirees should NOT enroll in Part D — Medicare Prescription Drug Plan. Enrollment in a Medicare Prescription Drug Plan is voluntary, but in most cases it is **unnecessary** because the Harris County Medical Plan administered through Aetna provides more comprehensive prescription drug coverage. In addition, there is **no** coordination of benefits between Harris County's medical plan and the Medicare Prescription Drug Plan; however, there will continue to be coordination with Medicare Parts A and B.

If you meet certain income and resource limits, Medicare's Extra Help Program may assist you by paying some of the costs of its prescription drug coverage. You may qualify if you have up to \$17,505 in yearly income (\$23,595 for a married couple) and up to \$13,440 in resources (\$26,860 for a married couple).

If you don't qualify for Extra Help, your state may have programs that can help pay your prescription drug costs. Contact your State Health Insurance Assistance Program (SHIP) for more information at 800-252-3439. Remember, you can reapply for Extra Help at any time if your income and resources change.

For more information about getting help with your prescription drug costs, call Social Security at 800.772.1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). If you or any of your covered dependents are eligible for additional coverage through **Medicaid**, you should contact 800-MEDICARE (800.633.4227) or visit [medicare.gov](https://www.medicare.gov) to determine the best prescription drug option for you.

**MONTHLY RATES
EFFECTIVE
MARCH 1, 2015**

MEDICAL

DENTAL

VISION

Rates apply to non-Medicare eligible Retirees

	BASE MEDICAL PLAN W/PPO DENTAL			BASE MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost	Retiree Cost	County Cost	Total Cost
Retiree Only	\$115.52	\$481.99	\$597.51	\$115.52	\$476.54	\$592.06
Retiree + Spouse	\$360.31	\$728.24	\$1,088.55	\$357.59	\$719.68	\$1,077.27
Retiree + Child	\$334.94	\$702.87	\$1,037.81	\$332.22	\$694.31	\$1,026.53
Retiree + Two or More	\$512.84	\$884.99	\$1,397.83	\$494.77	\$858.17	\$1,352.94

	PLUS MEDICAL PLAN W/PPO DENTAL			PLUS MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost	Retiree Cost	County Cost	Total Cost
Retiree Only	\$194.97	\$624.01	\$818.98	\$194.97	\$618.56	\$813.53
Retiree + Spouse	\$568.60	\$999.11	\$1,567.71	\$565.88	\$990.55	\$1,556.43
Retiree + Child	\$495.48	\$925.98	\$1,421.46	\$492.76	\$917.42	\$1,410.18
Retiree + Two or More	\$733.11	\$1,167.83	\$1,900.94	\$715.04	\$1,141.01	\$1,856.05

Retirees who were not eligible to retire by February 28, 2011 will pay an additional \$104.90 for their coverage.

NOTE: If you are currently covering dependents, Harris County may pay a portion of the cost of your dependents' coverage as well. If you retired after March 1, 2002 or if you retired with less than 10 years of Harris County service, your rates may vary. Please review your Enrollment Worksheet to determine the monthly rate for the 2015-2016 plan year for you and your currently covered dependents.

**MONTHLY RATES
EFFECTIVE
MARCH 1, 2015**

MEDICAL

DENTAL

VISION

Rates apply to Retirees eligible for Medicare.

	BASE MEDICAL PLAN W/PPO DENTAL				BASE MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost		Retiree Cost	County Cost	Total Cost
Retiree Only	\$0	\$481.99	\$481.99		\$0	\$476.54	\$476.54
Retiree + Spouse	\$244.79	\$728.24	\$973.03		\$242.07	\$719.68	\$961.75
Retiree + Child	\$219.42	\$702.87	\$922.29		\$216.70	\$694.31	\$911.01
Retiree + Two or More	\$397.32	\$884.99	\$1,282.31		\$379.25	\$858.17	\$1,237.42

	PLUS MEDICAL PLAN W/PPO DENTAL				PLUS MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost		Retiree Cost	County Cost	Total Cost
Retiree Only	\$67.13	\$624.01	\$691.14		\$67.13	\$618.56	\$685.69
Retiree + Spouse	\$440.76	\$999.11	\$1,439.87		\$438.04	\$990.55	\$1,428.59
Retiree + Child	\$367.64	\$925.98	\$1,293.62		\$364.92	\$917.42	\$1,282.34
Retiree + Two or More	\$605.27	\$1,167.83	\$1,773.10		\$587.20	\$1,141.01	\$1,728.21

Harris County pays a significant portion of the cost for your health care coverage. The amount of Harris County's contribution is determined annually and is currently based on your years of Harris County service and age at retirement. As a general rule, if you retired before March 1, 2002 with at least 10 years of Harris County service, for the 2015-2016 benefit year Harris County will pay 100% of the cost of your BASE plan medical, dental, vision and life insurance coverage if you are Medicare eligible.



COMMISSIONERS COURT

Ed Emmett • County Judge

El Franco Lee • Precinct 1 Commissioner

Jack Morman • Precinct 2 Commissioner

Steve Radack • Precinct 3 Commissioner

R. Jack Cagle • Precinct 4 Commissioner

Human Resources & Risk Management

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